C+D
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31 October 2009

RP: threat or opportunity?

The C+D Senate gives its verdict

See pages 20-24

Oilatum® — new 600 ml pack sizes help your patients achieve complete emollient therapy

Oilatum® Bath Emollients are now available in a range of 600 ml packs. They're bigger and last longer.*

The new packs represent a 20% increase in size, but only a 2% increase in price for Oilatum® Junior Bath and Oilatum® Emollient, while Oilatum® Plus has a price increase of 15%.*[1]

*compared with existing 500 ml packs.

New 600 ml pack sizes

Complete emollient therapy

Oilatum® Plus contains light liquid paraffin, benzalkonium chloride solution and triclosan.

Prescribing Information (Please refer to full Summary of Product Characteristics for Oilatum Junior before prescribing)
Oilatum® Junior (Light liquid paraffin 63.4% w/w)
Uses: Liquid bath additive for the treatment of contact dermatitis, atopic dermatitis, senile pruritus, ichthyosis and related dry skin conditions. **Dosage and administration:** Topical use only. Use as frequently as necessary. Oilatum Junior should always be used with water, either added to the water or applied to wet skin. *Adult bath:* Add 1-3 capfuls to an 8-inch bath of water, soak for 10-20 minutes and pat dry. *Infant bath:* Add ½-2 capfuls to a basin of water, apply gently over entire body with a sponge and pat dry. **Contra-indications:** None. **Precautions:** Patients should be advised to take care to avoid slipping in the bath. If rash or skin irritation develops treatment should be stopped. **Drug Interactions:** None known. **Pregnancy and lactation:** Safety in human pregnancy or lactation has not been established. **Side effects:** None. **Legal category:** GSL. **Presentation and Basic NHS cost:** 150ml £2.82, 250ml £3.25, 300ml £5.10, 500ml £5.75 and 600ml £5.89. **Product Licence (PL) number:** PL 0174/0182. **PL holder:** Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concorde Road, Maidenhead, SL6 4BY, UK. **Last date of revision:** Oct 2009. **Oilatum Junior** is a registered trademark of Stiefel, a GSK company.

Prescribing Information (Please refer to full Summary of Product Characteristics for Oilatum Emollient before prescribing)
Oilatum® Emollient (Light liquid paraffin 63.4% w/w)
Uses: Liquid bath additive for the treatment of contact dermatitis, atopic dermatitis, senile pruritus, ichthyosis and related dry skin conditions. Can also be used to cleanse the skin in conditions where the use of soaps, soap substitutes and colloid or oatmeal baths prove irritating. **Dosage and administration:** Topical use only. Oilatum Emollient should always be used with water, either added to the water or applied to wet skin, and may be used as frequently as necessary. *Adult bath:* Add 1-3 capfuls to an 8-inch bath of water, soak for 10-20 minutes, and pat dry. *Infant bath:* Add ½-2 capfuls to a basin of water, apply gently over entire body with a sponge, and pat dry. Skin cleansing: Rub a small amount of oil onto wet skin, rinse and pat dry. **Contra-indications:** None. **Precautions:** Patients should be advised to take care to avoid slipping in the bath. If rash or skin irritation develops treatment should be stopped. **Drug Interactions:** None known. **Pregnancy and lactation:** Safety in human pregnancy and lactation has not been established. **Side effects:** None known **Legal category:** GSL. **Presentation and Basic NHS cost:** 250ml £2.75, 500ml £4.57 and 600ml £4.68 **Product Licence (PL) number:** PL 0174/5010R. **PL holder:** Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concorde Road, Maidenhead, SL6 4BY, UK. **Last date of revision:** Oct 2009. **Oilatum Emollient** is a registered trademark of Stiefel, a GSK company.

Prescribing Information (Please refer to full Summary of Product Characteristics for Oilatum Plus before prescribing)
Oilatum® Plus (Light liquid paraffin 52.5% w/w, benzalkonium chloride solution 12% w/w, triclosan 2% w/w)
Uses: Bath additive for the prophylactic treatment of eczemas at risk from infection. **Dosage and administration:** Topical use only. Oilatum Plus should always be diluted with water. *Adults and children:* Add 1 capful to a 4 inch bath or 2 capfuls to an eight inch bath. *Infants:* Add 1ml and mix well with water. Do not use for babies younger than 6 months. **Contra-indications:** Hypersensitivity to any of the ingredients. **Precautions:** Avoid contact of the undiluted product with the eyes. If undiluted product does come into contact with the eye, reddening may occur. Eye irrigation should be performed for 15 minutes and then the eye examined under fluorescein stain. If there is persistant irritation or an uptake of fluorescein, then refer for ophthalmological opinion. Do not use with soap. **Drug Interactions:** None known. **Pregnancy and lactation:** No restrictions on the use of the product in pregnancy and lactation are proposed. **Side effects:** None known. **Legal category:** GSL. **Presentation and Basic NHS cost:** 500ml £6.98 and 600ml £8.05 **Product Licence (PL) number:** PL 0174/0070. **PL holder:** Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concorde Road, Maidenhead, SL6 4BY, UK. **Last date of revision:** Oct 2009. **Oilatum Plus** is a registered trademark of Stiefel, a GSK company.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk.
Adverse events should also be reported to Stiefel Laboratories (UK) Ltd at adverse.reaction@stiefel.com.

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PPA ABC

> ‘NO PHARMACIST MEANS A DYSFUNCTIONAL PHARMACY, UNABLE TO DISPENSE PRESCRIPTIONS OR SELL P MEDICINES’

Welcome to C+D – the Halloween special. Not a ghoul or goblin in sight, but there's still plenty to give you the jitters in this week's issue.

The responsible pharmacist (RP) changes have loomed over the profession this autumn with more menace than a coven of witches. But the verdict is out, according to C+D's Senate (p20), on whether we have given ourselves the heebie-jeebies over nothing.

Senators representing the UK's two biggest pharmacy multiples think we have little to fear. Premonitions of large numbers of pharmacists leaving premises under the new two-hour absence rule won't materialise, according to superintendents at Boots and Lloydspharmacy. No pharmacist means a dysfunctional pharmacy, unable to dispense prescriptions or sell P medicines. Until we address supervision, the multiples argue, the whole RP affair delivers little but a rise in red tape.

But other quarters vehemently disagree. RP does bring change for the worse, they argue. Frontline practitioners will be left to carry the can for breaches of standards laid down by their superintendent, and RP hasn't provided the clarity some people wanted over rest breaks, the Senate meeting heard.

Knowing how this will pan out in practice when confronted with such polarised views is something that only time will reveal. We know the multiples have met with their employee's trade union to discuss fallout from the regs. But, with both sides keeping quiet over what was said, we appear to be no closer to a satisfactory denouement.

While the verdict might be out on the full impact of RP, all sides agree we left it too late to prepare for the legislation. Above all, a cosmopolitan C+D Senate felt the industry should have sat down earlier to thrash out the practical issues surrounding RP. Novel solutions such as a universal SOP (p5) and an electronic RP register came out at our meeting. It's just a shame these ideas weren't explored earlier on.

Time to exorcise old ghosts

The industry has worked hard on the campaign to decriminalise dispensing errors. Worrying then to read a High Court judge express sympathy for criminal sanctions as he threw out a dispenser's appeal against a conviction this week (p5). The pharmacist involved in the same error was also convicted in 2008.

The case predates Elizabeth Lee's and the bid for decriminalisation. But it must be used to breathe fresh impetus into the campaign. There's been nothing but eerie silence over the progress of talks to freeze criminal prosecution of errors since they were announced this summer.

This unfair law must change sooner rather than later. It's time to exorcise the ghost of The Medicines Act 1968 once and for all.

Max Gosney, News Editor

No priority swine flu jabs for pharmacists in a third of PCTs

EXCLUSIVE Lack of consistency as neighbouring PCTs split over pharmacists' priority status

Chris Chapman
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Almost a third of PCTs have no plans to include the majority of pharmacists in the first wave of swine flu vaccinations despite government guidance, C+D can exclusively reveal.

In information obtained under the Freedom of Information Act, C+D asked PCTs in England whether pharmacists and staff were included in their plans as a priority group for the swine flu vaccine. Of the 72 PCTs to respond, 22 said pharmacists had been left out of plans, with 37 confirming pharmacists would be inoculated. The remaining 13 PCTs stated plans were still to be finalised or did not divulge the information.

The responses, received between September 1 and October 9, showed neighbouring PCTs and even cities split over who should get the vaccine: pharmacists in South Birmingham PCT are guaranteed the jab as a priority, while colleagues in Birmingham East and North PCT are not included as a priority group.

Fourteen of the 22 PCTs not to offer the vaccine responded to C+D after guidance urging them to include pharmacists involved in front line care was sent by director of NHS flu resilience Ian Dalton and PSNC chief executive Sue Sharpe. Staff in at least 87 pharmacies involved in the distribution of antiviral Tamiflu will miss out on the priority jab, according to PCT responses.

The inconsistencies have provoked outrage from some pharmacists. Keith Howell, a pharmacist for Delmergate in Herne Bay who has been offered the vaccine, said it was unfair others were left unprotected.

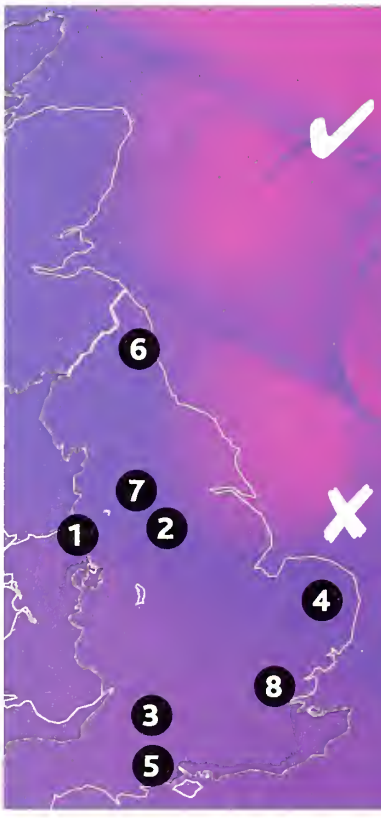
He said: "We're all doing the same job, and there shouldn't be that discrepancy."

However, several trusts offering the vaccine to pharmacists and staff praised the important role the sector plays in primary care, with Newham PCT stating pharmacists "are key to so many areas they are a local priority for vaccination".

The news came as swine flu rates doubled in England, with latest figures from the Health Protection Agency reporting 53,000 new cases a week. GP consultation rates are now above the baseline threshold for a seasonal flu outbreak.

Last week pharmacy bodies and the Department of Health united to call on pharmacists to accept the vaccine if offered, with DH community pharmacy tsar Jonathan Mason stressing the importance of the jab in an exclusive video for C+D.

See how PCTs responded
www.chemistanddruggist.co.uk



PCTs: the good and the bad

The good:

1. WIRRAL: "Planning is under way based on the premise that all eligible pharmacists and their staff will be offered the vaccine"

2. KIRKLEES: "If vaccine availability permits then all community pharmacists will be included"

3.SWINDON: "Pharmacists with clinical roles, and pharmacy staff in antiviral collection points will be offered the vaccine"

4. NORFOLK: "Community pharmacists and their front line staff will be treated as key health workers"

5. DORSET: "All community pharmacists in the PCT have been invited to submit lists of staff who have direct patient contact"

The bad:

6. SOUTH TYNESIDE: "Pharmacists who provide services previously delivered by doctors and nurses" will get the jab, which will be a "limited number"

7. HEYWOOD, MIDDLETON AND ROCHDALE: "They are not included in the first priority group. When/if further stocks of the vaccine are made available they will be considered for vaccination"

8. MID-ESSEX: "In line with national guidance these staff are not considered a priority group"

Get the swine flu vaccination if you can, says Jonathan Mason in his latest videoblog

www.chemistanddruggist.co.uk/mason

Early sales surge for OTC winter remedies

Pharmacy companies have supported market reports of an early surge in winter remedy sales this year.

Market analyst Mintel last week reported an early start to the cough and cold season and predicted that Brits would spend over £520 million on OTC winter remedies this year, a 3 per cent increase compared to 2007.

And Lloydspharmacy and Rowlands both said the category was doing well for the time of year, with Lloydspharmacy superintendent pharmacist Nick Mortimer reporting a "significant increase in sales" compared to the same two-week period last year.

But Rowlands managing director Kenny Black said this appeared to be due to an increase in advance sales rather than greater incidence of colds and flu. "Perhaps this is due to the extensive media coverage of swine flu, so people are stocking up," he said.

Lloydspharmacy had seen "strong sales" in cold and flu prevention products as well as remedies, Mr Mortimer agreed.

However, an Asda spokesperson said it had seen "nothing out of the ordinary" in winter remedy sales for the time of year.

The winter remedies market has grown 70 per cent since 2005, Mintel said, and was expected to grow a further 8 per cent by 2013. **JR**

How to handle a swine flu patient with an invalid Tamiflu collection number

See p18

Dispenser loses appeal against error conviction

Ruling could leave other pharmacy staff exposed, legal expert warns

Jennifer Richardson/Strand News
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A dispenser has lost her appeal to overturn a criminal conviction for a single dispensing error, raising questions about the liability of other pharmacy staff.

Georgina Mahoney, of Lloydspharmacy, Prestatyn, was rightly convicted and fined for her part in a patient being given antidepressant sertraline instead of a diuretic, London's High Court ruled last week.

The patient subsequently died, but there was no suggestion the dispensing error caused or contributed to his death, the court heard.

Ms Mahoney's barrister argued that because she was not a pharmacist she could not have "supplied" the drug. The pharmacist on duty was also fined and given a criminal conviction when the case was heard last September, and did not appeal.

But the appeal judge ruled that Ms Mahoney was "plainly part of the system of supply" and that the law imposed strict duties on all who handled prescriptions due to the potential consequences of a mistake.

The ruling suggested other pharmacy staff, such as counter assistants not involved in dispensing but who hand prescriptions out, could also be liable, said pharmacy legal expert Noel Wardle.

"What about the delivery driver?" added Mr Wardle, of law firm Charles Russell. "Does he have to open every bag before he hands it out? This case suggests he does because he is definitely part of the supply."

Pharmacy staff positions may be more difficult to fill or require salary increases as a result of increased responsibility implied by the case, Mr Wardle suggested.

The case "broadened" the issue raised by the Elizabeth Lee case earlier this year, he added. Pharmacy bodies launched a campaign to overhaul the 1968 Medicines Act, after it was used to secure a conviction against Ms Lee for a single dispensing error.

Mr Wardle and other experts said Ms Mahoney's failed appeal did not adversely reflect upon these efforts because the case predated the Elizabeth Lee case.

C+D Senate calls for universal SOP to solve practical challenges of RP

Industry leaders have pledged to investigate adopting a universal SOP to help responsible pharmacists get a quicker understanding of a pharmacy's work processes when signing on for work.

The safeguard was tabled by the C+D Senate at a meeting to debate practical challenges around responsible pharmacist legislation.

Under rule changes, pharmacies must have an RP signed on before they can dispense POM medicines or sell P and GSL products.

The changes mean locums are under pressure to sign on as RPs straight away at unfamiliar pharmacies, the Senate heard.

C+D Senator and PDA chair Mark Koziol said: "The pharmacist has to be able to digest the SOP before signing on... I think the solution needs to be the profession needs to develop a very simple, top-line, no more than one and a half pages, SOP."

Pharmacists could memorise the document like "the 10 commandments", Mr Koziol added.

Boots vowed to explore the idea with the PDA. "I see the benefit of a single approach," said Paul Bennett, C+D Senator and Boots superintendent pharmacist. Whether you can take that out across 12,000 pharmacies is another matter... but that doesn't mean we shouldn't look at it."

The C+D Senators debated how a universal pharmacy SOP could work in practice

Fellow pharmacy multiple Lloydspharmacy also expressed interest in the universal SOP concept. Nick Mortimer, C+D Senator and Lloydspharmacy superintendent, commented: "It's a very interesting point. I would welcome it if we could do it. I do have some scepticism around how practical [this is], whether a page and a half is too optimistic."

Lloydspharmacy SOPs run to 198 pages following work to cut back documents to the "bare minimum" in readiness for RP, Mr Mortimer revealed. His comments came at the second meeting of the C+D Senate – an industry think-tank set up to tackle key pharmacy issues.

The industry had failed to act fast enough to address many practical issues around RP, Senators representing the RPSGB, NPA and grassroots pharmacy ruled. **MG**

Read more on pages 20-24

NCSO for fluoxetine

The Department of Health and National Assembly for Wales have agreed to allow NCSO endorsements for fluoxetine capsules (20mg) for October 2009 prescriptions.

Win £500 of training

Complete the Future of Pharmacy survey from GSK Plus, which is included in this issue, and you could win £500 for you and your pharmacy team to spend on Medway School of Pharmacy and C+D educational courses. **www.chemistanddruggist.co.uk/GSKPlussurvey**

Share patient data call

PSNC has called for PCTs, LPCs and hospital pharmacists to share information on recently discharged patients with community pharmacists. The call came in response to a report by the Care Quality Commission highlighting failures in prescribing for patients who have recently left hospital.

Grand designs – win £6k

Has your pharmacy, or one of your company's pharmacies, been refitted to an exceptional standard since January 2008? Then why not enter it for the Platinum Design Awards for a chance to win a share of £6,000 prize money? Call 01732 377269 for details or download an entry form at **www.chemistanddruggist.co.uk/pda2010**

Lloyds backs VAT delay

Lloydspharmacy has backed proposals for extra time to implement the VAT rate change. The government has proposed extending the two-week period retailers have to adjust price labels to reflect the reversal in VAT from 15 to 17.5 per cent on January 1.

Pharmacy does what?

A survey carried out by the Patients Association found almost half of 700 interviewees did not know they could have cholesterol or blood pressure tests at their local pharmacy. **www.chemistanddruggist.co.uk**

In brief

RPSGB elections

The RPSGB is seeking candidates "passionate about the future of the profession" to stand for the national pharmacy boards of England, Scotland and Wales. Nominations must be in by November 23.
www.rpsgb.org

CPD clarification

C+D would like to clarify that pharmacists who don't submit CPD when repeatedly asked by the Society will face referral to its Fitness to Practise department not its Investigating Committee (IC) (C+D, October 24, p5). Members can be referred to the IC, but only after meeting certain threshold criteria. For more on CPD reporting, go to **www.chemistand druggist.co.uk/education**

Rowlands relocation

Rowlands has relocated its Portsmouth pharmacy to a purpose-built £4 million development shared with a GP surgery.
www.chemistanddruggist.co.uk

TV volunteers wanted

Factual programme-maker Lion Television is looking for pharmacists to appear in a documentary about the life and work of a 19th century high street chemist. If you are interested in volunteering, email your CV or a short biography to richard.shaw@liontv.co.uk.

Boots health website

Boots has launched a consumer website with US online health information provider WebMD. The site will draw on the expertise of NHS Choices and the BMJ, and "aims to provide the most objective, trustworthy and engaging health information on the net for UK customers", Boots said.

The NHS needs to save £15bn, but what does it mean for you? Read Georgina Craig's comment at
www.chemistanddruggist.co.uk/opinion

DH pledges action to tackle stock shortages

Health chiefs to issue warning against exports, MPs hear

Chris Chapman
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The Department of Health (DH) is to take action on stock shortages by urging the supply chain to stop parallel exports, but has admitted its powers are limited.

The announcement came as a parliamentary meeting heard the cost of the current stock shortage has risen to more than £30 million. At least 200 medicines are affected, and the loss of parallel imports may be the main reason for dwindling stocks, pharma chiefs told the all-party pharmacy group (APPG) this week.

The DH had been talking to manufacturers, wholesalers and pharmacy bodies and would be "working collaboratively to issue guidance" shortly, DH head of pricing, supply and prescriptions Luisa Stewart told the meeting.

The DH had already told hospital trusts to stop parallel exporting after anecdotal evidence revealed they had been involved in parallel trade, Ms Stewart said. But she admitted the DH had no power to stop trusts exporting. She said: "They're acting voluntarily. But as far as we're concerned they're not doing it."

Mark James: parallel exports are not the only reason for the drugs drought

Manufacturers had increased supply by up to 200 per cent to meet the increased demand for medicines, ABPI director-general Richard Barker told the APPG meeting.

However, AAH managing director Mark James said exports were only part of the picture in a supply chain that had become "more fragile" over the past decade. The dry-up of parallel trade due to the pound-euro exchange rate had increased UK demand for some drugs five-fold, he argued.

"I'm not arguing exporting isn't an issue, but some of this is driven by the dry up of imports."

The APPG meeting on Tuesday was called to debate stock shortages affecting the sector.

RPSGB redundancies ahead of Scottish move

The Royal Pharmaceutical Society has made half its Scottish division staff redundant as it prepares for new premises.

Three of six people working for the Scottish Directorate had been let go, director Lyndon Braddick told C+D, while three new posts had been created "to improve communication with members".

Mr Braddick declined to reveal which posts had been made redundant, but said those affected would receive "enhanced redundancy packages" following "a statutory three months' notice".

A locum practice forum facilitator had already been recruited, he added, and the search for website content and public relations posts was underway.

The changes were "associated" with the division's premises move, due by the end of the year, Mr Braddick said. The Society will move from existing offices at York Place, Edinburgh to a "prestigious" site in the city centre. The new premises would provide better facilities for members, the RPSGB said, including an information centre, "flexible" meeting rooms and disabled access.

Mr Braddick was unable to reveal the cost of the move but said more details would be made available when the lease was signed. **JR**

Society hits three of 21 targets by mid-point

The RPSGB has completed three out of 21 promised actions at the halfway stage of a 100-day pledge to demonstrate its vision for the future professional leadership body.

The Society has detailed progress made on the majority of the remaining pledges.

President Steve Churton set out seven commitments to support members in September and promised to demonstrate them within 100 days.

Fifty days in, the three targets the Society had ticked off were:

- building an online communications network
- appointing five local practice forum facilitators
- participating in negotiations on the decriminalisation of dispensing errors.

A Society spokesperson said: "We are planning to feed back to members in the next few weeks on the 100-day deliverables." **JR**

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new
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ABBREVIATED PRESCRIBING INFORMATION (UK)
ellaOne® (ulipristal acetate). Please refer to the SmPC before prescribing ellaOne® **Presentation:** White/off-white, round curved tablet engraved "II" on both faces. **Indications:** Emergency contraception within 120 hours (5 days) of unprotected sexual intercourse or contraceptive failure. **Dosage:** One 30mg tablet to be taken orally as soon as possible, but no later than 120 hours after unprotected intercourse or contraceptive failure; with or without food. Another tablet should be taken if vomiting within 3 hours of intake. ellaOne can be taken at any point during the menstrual cycle. Pregnancy should be excluded. *Renal or hepatic impairment:* no specific dose recommendations can be made. *Severe hepatic impairment:* not recommended. *Children and adolescents:* Safety and efficacy only established in women ≥18 years. **Contra-indications:** Hypersensitivity to the active substance or excipients. Pregnancy. **Special warnings and precautions for use:** Concomitant use with an emergency contraceptive containing levonorgestrel is not recommended. Use in severe asthma insufficiently controlled by oral glucocorticoid is not recommended. Emergency contraception only; women should be advised to adopt a regular method of contraception. May reduce contraceptive action of regular hormonal contraception; subsequent acts of intercourse should be protected by a reliable barrier method until next menstrual period. Repeated administration within the same menstrual cycle is not advisable. No data for unprotected intercourse more than 120 hours before intake. Does not prevent pregnancy in every case; delay of >7 days in next menstrual period, abnormal bleeding at menses, or symptoms of pregnancy, exclude pregnancy. If pregnancy occurs, possibility of an ectopic pregnancy should be considered. Menstrual periods can sometimes occur earlier or later than expected by a few days. In ~6%, menstrual periods occurred >7 days early. In ~20% a delay of >7 days occurred, and in 5.1% the delay was >20 days. Contains lactose monohydrate; patients with galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should avoid. **Drug interactions:** Ulipristal acetate is metabolized by CYP34A *in vivo*. No specific drug interaction studies have been performed *in vivo*. **Potential for other medicinal products to affect ulipristal acetate:** CYP34A inducers (e.g. rifampicin, phenytoin, phenobarbital; carbamazepine, ritonavir, St John's Wort/Hypericum perforatum) may reduce plasma concentrations of ulipristal acetate and decrease efficacy, even if stopped enzyme inducer within last 2-3 weeks. Concomitant use not recommended. Concomitant administration of medicinal products that increase gastric pH (e.g. proton pump inhibitors, antacids and H2-receptor antagonists) may reduce plasma concentrations of ulipristal acetate and decrease efficacy and therefore not recommended. Potent CYP34A inhibitors (e.g. ketoconazole, itraconazole, telithromycin, clarithromycin, nefazodone) may increase exposure to ulipristal acetate. Clinical relevance unknown. **Potential for ulipristal acetate to affect other medicinal products:** Because ulipristal acetate binds to the progesterone receptor with high affinity, it may interfere with action of progestogen-containing medicinal products. Contraceptive action of combined hormonal contraceptives and progestogen-only contraception may be reduced. Concomitant use of ulipristal acetate and emergency contraception containing levonorgestrel not recommended. **Pregnancy and lactation:** Contra-indicated during existing or suspected pregnancy. Extremely limited data available on health of the foetus/new-born in pregnancy exposed to ulipristal acetate. No teratogenic potential was observed; animal data insufficient with regard to reproduction toxicity. HRA Pharma maintains a pregnancy registry to monitor outcomes of pregnancy in women exposed to ellaOne. Patients and health care providers are encouraged to report any exposure to ellaOne by contacting the Marketing Authorisation Holder. Unknown whether ulipristal acetate is excreted in human or animal breast milk. A risk to the breast-fed child cannot be excluded: breastfeeding not recommended for ≥36 hours after intake. **Undesirable effects:** Always consult the SmPC before prescribing. *Very common (≥1/10):* abdominal pain, menstrual disorder. *Common (≥1/100 to <1/10):* infections, mood disorders, headache, dizziness, nausea; vomiting, dyspepsia, muscle spasm, back pain, dysmenorrhea, menorrhagia, metrorrhagia, fatigue. *Uncommon (≥1/1,000 to <1/100):* Appetite disorders, psychiatric disorders, mood disorders, depression, anxiety symptoms, insomnia, libido disorders, irritability, somnolence, tremor, vision blurred, hot flush, diarrhoea, constipation, dry mouth, flatulence, acne, rash, pruritus, musculoskeletal pain, pollakiuria, breast pain, genital pain, uterine spasm, premenstrual syndrome, genital pruritus, vaginal discharge, pain. *Rare (≥1/10,000 to <1/1,000):* dehydration, disturbance in attention, lethargy, vertigo, sinus congestion, cough, epistaxis, dry throat, gastro-oesophageal reflux disease, glossitis, toothache, urticaria, nephrolithiasis, renal pain, chromaturia, ruptured ovarian cyst, chest discomfort, inflammation, malaise, pyrexia, thirst, chills. **Package quantities and basic NHS price:** ellaOne 30 mg Tablet Oral use 1 tablet blister pack: £16.95. **Marketing authorisation holder:** Laboratoire HRA Pharma, 15, rue Béranger, F-75003 Paris, France. Marketed in the UK by: HRA Pharma UK Limited, Unit 7, RB Building, 557 Harrow Road, Kensal Green, London W10 4RH. **Marketing authorisation number(s):** EU/1/09/522/001. **Legal category:** POM. **Date of last revision of the API text:** 18th August 2009.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to HRA-Pharma UK Ltd on 0800 917 9548 or email med.info.uk@hra-pharma.com.

Reference: 1. CHMP Assessment Report for ellaOne. Procedure No. EMEA/H/C/001027. Available at www.emea.europa.eu

Further information available from:

HRA Pharma UK Ltd
Unit 7, RB Building, 557 Harrow Road, Kensal Green, London W10 4RH
Tel: 0800 917 9548 Email: med.info.uk@hra-pharma.com

Item code: 106/ELLA/Sept/09/AS. Date of preparation: September 2009

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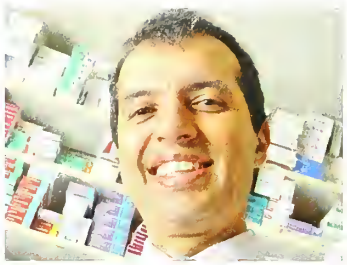
Dispensary talk

Have you been offered the swine flu vaccine?



"I will be in due course. They have not rolled it out completely here yet but we have been told we will be included."
Raj Radia, Spring Pharmacy, Hackney, London

"Not so far and the staff here are 50/50 about the whole thing. Some want to have it and some do not."
Lorraine Moore, Rowlands Pharmacy, Sunderland

"No. We got early hype on it and then they had decided where to push it out. We seemed to miss a stage."
Brian Deal, Ashwell Pharmacy, Herts

Web verdict

Yes 26%

No 74%

Armchair view: Only one in four pharmacists out there have been offered vaccinations. Looks like the PCTs are failing to bring home the bacon.
Next week's question: Should dispensing staff be liable for dispensing errors? Vote at **www.chemistanddruggist.co.uk**

Contractor pursues his 'missing £10k' from NHS

Payment errors included complete omission of professional fees

Jennifer Richardson
jrichardson@cmpmedica.com

A contractor has slammed NHS paymasters after he was underpaid £5,000 and believes he is still missing even more.

When Walter Motie's May prescription payment was £10,000 to £12,000 lower than usual, he asked NHS Prescription Services (NHS PS, formerly the PPD) to recheck.

NHS PS subsequently paid the north London contractor an additional £5,000 after errors including the complete omission of his professional fees were identified. Mr Motie told C+D: "They should not be making those kinds of errors."

And he believes he is still missing up to £7,000 as the payments for Porter Pharmacy, which he has run for 18 years, fluctuate very little.

Mr Motie claimed he had heard nothing from NHS PS since he last contacted them four weeks ago and was "running out of steam" chasing the problem. "I don't know what to do, where to go," he said. "It's on your mind when you're trying to get on with your work."

An NHS PS spokesperson said it could not discuss contractors' accounts but added: "We have carried out some investigation in relation to Mr Motie's queries and are progressing outstanding issues as quickly as possible."

Like other contractors who have contacted C+D, Mr Motie has also seen an increase in the number of his prescriptions switched from exempt to paid status – from just one or two most months to almost 40 for June, he said. NHS PS has previously said the automated pricing system it introduced in 2007 has increased the pick-up rate for incorrectly sorted scripts and that its accuracy level is 98.5 per cent.

Walter Motie: NHS Prescription Services should not make these kinds of errors

Alphega offers discount on Alliance Healthcare products

Members of virtual pharmacy chain Alphega will receive a discount of up to 1 per cent off all Alliance Healthcare, OTC direct and Cordia products.

The saving was announced at the relaunch of Alphega's full membership package for independent pharmacies last week.

The discount, which ranges from 0.75 per cent to 1 per cent depending on membership level, will effectively negate the £499 monthly membership cost, Alphega general manager Sue Moore said.

Pan European group Alphega currently has 267 members in the UK and aims to expand to more than 850 by 2013, Ms Moore said. However, she insisted the chain wasn't focused on the number of stores under its banner.

"It's not about numbers, but about quality. We don't want to expand too fast, we've got to keep lean and flexible," she said. The chain had turned down some applicants who did not have suitable premises or were not interested in developing and growing their business, Ms Moore added.

The revamped Alphega package also promises extended business support services such as bespoke advice from a business mentor and access to consultants in retail, design and marketing.

Earlier this month Alliance Boots director Ornella Barra revealed Alphega was a key part of the company's global strategy in an exclusive interview with C+D. **CC**

Fuel surcharge back at AAH

AAH has announced it will reintroduce its fuel surcharge from December, unless fuel prices drop.

AAH group managing director Mark James said the company had shielded customers from price increases but at current levels or higher AAH had "no option but to apply a surcharge" of £2.35 from December 1.

Diesel prices rose from 99.8p per litre in March to 108.4p per litre this month, according to the AA.

The move comes after Alliance Healthcare reintroduced its own mandatory £2.50 surcharge earlier this month.

Mr James added that AAH believed that customers should be able to reclaim the charge as an expense. **JC**

Commitment 7:

We will advance the science and practice research base for pharmacy and healthcare.

On the 7th September we announced a series of commitments that underline how the professional leadership body (PLB) intends to become the body you have asked for.

Our seventh commitment is to 'advance the science and practice research base for pharmacy and healthcare.'

Here are the actions we will take over the next 100 days to demonstrate our commitment:

- Review the most effective commissioning and funding routes for pharmacy practice research.
- Redefine the relationship with the Pharmacy Practice Research Trust to help maximise the value of their work.
- Build a database of pharmaceutical science experts willing to contribute to the work of the PLB in their area of expertise.

To keep an eye on our progress, suggest future actions we can take, and to read about the rest of the commitments in full, visit **www.pharmacyplb.com**

'I believe that it is essential to recognise the importance of research in pharmacy. It is promising to know that the new professional body has made a commitment to advancing the science and practice research base for pharmacy and healthcare; this will mean that we can stay ahead of our game.'

Zaynab Nejadhamzeeigilani, Pharmacist and PHD Student

RPSGB is working with the profession to build a new professional leadership body for pharmacy

www.pharmacyplb.com

Sugar-free flucloxacillin from Actavis

Actavis is adding a sugar-free formulation to its flucloxacillin oral solution range.

Flucloxacillin sugar-free oral solution is available in two strengths: 125mg/5ml and 250mg/5ml. The product is indicated for the treatment of infections due to sensitive Gram-positive organisms.

"This innovative product offers our customers and patients a sugar-free option for a well established molecule," said Actavis director Jonathan Wilson.

The company will continue to supply flucloxacillin 125mg/5ml and 250mg/5ml sugared oral solution.

The products are available from the company's Accumulator wholesale partners.

NHS prices and Pip codes: £21.87 125mg/5ml x 100ml, 114-8568; £26.87 250mg/5ml x 100ml, 114-8576
Actavis UK
Tel: 01271 311200

New name for dry eye spray

Liposomal eye spray for dry eyes has been renamed Eye Logic Dry Eye spray.

Eye Logic contains the same natural soya lecithin formulation to provide relief for dry eyes. It is designed to reduce the rate of evaporation of the tear film, leaving the eyes feeling soothed and refreshed.

The product is sprayed onto closed eyelids, making it suitable for people who find drops inconvenient or uncomfortable. It can also be used by contact lens wearers and can be sprayed over the top of make-up without making it run.

"The decision was taken to change the name to more closely align the product with the eye health market and allow for future product line extensions," says David Gunning, marketing manager for Savant Distribution.

Market focus

- The eyecare treatment market is one of the most dynamic and fast growing OTC markets.
- The £55 million market is growing by over 14 per cent year on year.

Source: IRI value sales 52 w/e October 3, 2009

Price and Pip code: £12.67/10ml (100 metered doses), 231-5885
Savant Distribution
Tel: 08450 606070
www.eye-logic.co.uk

NiQuitin Minis offer flexi approach to quitting

GlaxoSmithKline will support its new small oral therapeutic nicotine product NiQuitin Minis with a £1.7 million consumer advertising campaign during November.

NiQuitin Minis 4mg have been launched to provide an option for smokers who want to break the quitting journey down step-by-step, allowing them to quit one cigarette at a time.

The product is designed to be fast-acting and can control cravings within five minutes, says GSK. It comes in a handy pocket-sized pack, making it easy to use on-the-go.

Darush Attar-Zadeh, stop smoking specialist and pharmacist from Hounslow, London, commented: "This new product offers smokers a flexible approach and we can tailor a quit attempt to a person's individual needs. Pharmacists can play a key role in identifying and educating smokers about these different methods, which will hopefully lead to more quit attempts."

Price: £4.99/20
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
www.niquitin.co.uk

Beechams comes out fighting

Four genuine Sumo wrestlers provide heavyweight support for Beechams this winter, focusing on the brand's strongest cold and flu relief range – Beechams Ultra All in One.

Worth around £5 million, the campaign includes national TV and radio advertising and is designed to show that the new range has the strength to tackle cold and flu symptoms.

On air from November 1 for three months, the TV coverage features Becky on her way to work being confronted by the wrestlers who represent four cold and flu symptoms: headache, sore throat, chesty cough and runny nose.

Having taken Beechams All in One, she feels better and with confidence, grows in stature. With a twinkle in her eye, she sends the Sumo wrestlers/symptoms packing and is able to carry on with her day.

The Sumo wrestler theme has also been extended to point of sale material for pharmacies (pictured).

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

PoS campaign Nurses it better

GlaxoSmithKline is supporting its Nurses cold and flu P-line with an eye-catching point of sale (PoS) campaign in pharmacies this winter.

GSK says its strategy is to create awareness and high visibility throughout the pharmacy in a drive to increase sales at the pharmacy counter.

Bold dummy packs, double-sided posters, window standees and wobblers are designed to steer customers to the pharmacy counter.

Other PoS material such as script maps, tent cards, counter top units and shelf strips for the back wall will help to educate customers at the point of purchase.

The campaign will highlight Night Nurse with the full Nurses range featured where space allows.

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

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EPS chaos looms despite our warnings

> IF THE SUPPLY CHAIN ISN'T ALREADY ON ITS KNEES, IT'S CERTAINLY BENDING OVER AT A PRECARIOUS ANGLE

It's Halloween and strange and scary things are happening. But we're still short of witches and wizards – or at least someone with a clear agenda and a bit of magic.

I have often wondered about our professional bodies' agendas, but their recent admission that they're not sure whether EPS is worth all the fuss (C+D, October 24, p6) beggars belief. I, and many other pharmacists, have been questioning the merits of EPS for years only to be repeatedly reassured that everything would be fine. Now suddenly, many years down the line and when it is far too late to make any constructive changes, they seem to be getting cold feet.

How on earth am I supposed to positively engage with release 2 when PSNC is not sure whether it will have an adverse effect on the safe and efficient supply of medicines? And the NPA cannot "evaluate the overall benefit of EPS until the latest pilot has been evaluated"? I can imagine explaining this to patients: "This is a great new system, Mrs Jones, but we'll just have to cross our fingers that I can still safely supply your medicines."

It's no wonder some IT system suppliers have given up on the NPA's IT forum. It could mean that system suppliers will continue to implement release 2 at the behest of the Department of Health without any reference to pharmacists at all.

The horse has well and truly bolted now, so it's futile to try and undo some of the damage that's already been done. There's no doubt in my mind that release 2 will create more unnecessary work for me. Which 'progressive' initiative in recent memory hasn't? But if there's a possibility that it will affect my ability to safely and effectively supply medicines I cannot imagine how it has got to the stage where it looks like an unstoppable runaway train.

I'm surprised that some multiples don't seem to have seen this coming either, claiming only two weeks ago that release 2 could bring the supply chain to its knees within a week (C+D, October 17, p6).

But there's nothing new there – if the supply chain isn't already on its knees, it's certainly bending over at a precarious angle. And that issue is being dealt with in a similar way to EPS. The supposedly great and good sit around blaming each other for the mess they're all in, while grassroots pharmacists are left to pick up the pieces.

A hint of the future came from the MD of Lloydspharmacy, who talked at the C+D Conference about increasing automation and pharmacist avatars. Let's hope they're programmed to deal with situations such as supply chain problems, EPS failures and flu pandemics etc.

Why care homes really need your help

I was listening to the radio at 7am when a voice came into my earphones. "Can you hear me? Great, we'll come to you around 20 past." I started to feel even more nervous; my first live radio interview was going to be on Radio 4's Today programme.

I was in a claustrophobic studio in BBC Radio York (I was in York to attend the RPSGB Council meeting); I felt sure the mike could pick up my heart beat.

The voice said: "You are on next" and shortly afterwards I heard Justin Webb say: "A report commissioned by the Department of Health has shown that seven out of 10 care home residents have a medication error. We can speak to an author of the report, Professor Nick Barber."

I still cannot remember the rest of the interview, but they replayed it later in the programme, and also on Radio 2, so it can't have been too bad. We also got into the broadsheets and the Daily Mail. By the end of the week there were over 100 references in the media to our research.

What can we learn from this? First, that research can highlight the problems there are with medicines, and so raise interest in the subject on which we are the experts. Second, that we can influence the policy agenda – we are already getting indications of this. Now we need to show that pharmacists can lead in improving matters.

Our key finding is that there are errors across the board – around eight to 10 per cent in prescribing, dispensing and administration (and even higher for the monitoring of important drugs).

What we need is the pharmacist, home and prescriber acting as a team. I know this may be far easier said than done, however everyone can make some steps towards it. I would be expecting chief pharmacists of PCTs to help as it is their responsibility to ensure safe medication systems.

If you supply a care home, or you want to advise one, then talk to the manager – they are really worried about medicines and want help (they gave us fantastic collaboration in our study). Our paper explains the problems we found and so provides you with a sort of checklist of things that may be a problem (the paper is available at http://qshc.bmj.com/cgi/content/full/18/5/341; email n.barber@pharmacy.ac.uk if you want the detailed report).

Pick up the phone and call a care home today. There is a small chance you'll save a life, and a much greater one that you will just improve the quality of life of some of the most vulnerable patients we care for.

Professor Nick Barber, Centre for Medication Safety and Service Quality, The School of Pharmacy, University of London

> PICK UP THE PHONE AND CALL A CARE HOME TODAY. THERE IS A SMALL CHANCE YOU'LL SAVE A LIFE

Features

C+D Senate ▶

The C+D think-tank meets to debate the new responsible pharmacist rules

▲ Update

Recognise and treat bacterial vaginosis

▲ Practical Approach

Treatments and causes of hirsutism

▲ Ethical Dilemma

A patient has the wrong URN for his antiviral

▲ Jobs

Shafique Govani on his switch to pharmacy

Update

Your weekly CPD revision guide

Module 1501

Bacterial vaginosis

It is normal for vaginal discharge to change throughout the menstrual cycle, but what signs would be considered abnormal?

60-second summary

What is bacterial vaginosis and how/when should it be treated?

Bacterial vaginosis is the most common cause of abnormal vaginal discharge in women of childbearing age. The condition is caused by an overgrowth of anaerobic bacteria, particularly Gardnerella vaginalis, which results in the vagina becoming less acidic and the development of a characteristic fishy-smelling discharge, though about half of sufferers will be asymptomatic.

The recommended first-line treatment is metronidazole 400mg twice daily for seven days, which is around 80 per cent effective. Other treatments, such as single dose metronidazole, other antibiotics or topical antibacterial agents, are considered less effective and more expensive.

Only patients with symptoms require treatment, except for pregnant women when all should be treated due to a link between BV and miscarriage, premature birth and low birthweight. No standard treatment for recurrent symptoms exists because of a lack of supporting evidence.

This article (Module 1501) can help in the following CPD competencies: G1a, G1c, G1d, G2c, G3a. See http://tinyurl.com/68ox7b

Asha Fowells MRPharmS

It's a busy Monday morning in the pharmacy and you are at the counter giving advice to a patient who has just collected his inhaler. As you finish and the patient turns to leave, a woman steps forward, saying: "Excuse me, I know you're very busy but could I have a word? In private, if possible."

The woman sits down in the consulting room and says: "I'm sorry to make a fuss, it's just I've got this awful discharge – you know, down below – and it really smells. I'm a married mum of two with another on the way, and I'm mortified. What can I do?"

Symptoms

Vaginal discharge is usually nothing to worry about. All menstruating women – though not those on hormonal contraceptives – will experience discharge that changes throughout their menstrual cycle. For most of the month, it will be thick and sticky, but around ovulation it becomes clearer, thinner and stretchy.

Abnormal vaginal discharge is characterised by a change in colour, odour, consistency or quantity, and may be accompanied by other symptoms, such as itching, soreness, pain, dysuria, and abnormal vaginal bleeding.

Causes

The causes of abnormal vaginal discharge fall into two categories: infections and non-infective causes. **Infections** are by far the most common cause, with bacterial vaginosis (BV) the most common culprit in women of childbearing age.

BV is caused by an overgrowth of anaerobic bacteria (particularly Gardnerella vaginalis, but also Prevotella and Mobiluncus species, and Mycoplasma hominis) and a loss of the lactobacilli usually present in the vagina, which in turn results in the pH rising from its usual 4.5 to as high as seven.

About half of women suffering from BV will be asymptomatic, but those who do have symptoms are likely to report a fishy-smelling discharge.

Other infective causes of abnormal vaginal discharge include the sexually transmitted infections chlamydia, trichomoniasis and gonorrhoea. However, these are more common in younger women and those who have recently changed their sexual partner, and are distinguished from BV by the accompanying symptoms of itching, soreness or irritation, all of which are generally absent in BV, and a different type of discharge.

Vaginal candidiasis (thrush) can cause abnormal vaginal discharge, but – as with the STIs listed above – is easily distinguishable from BV by accompanying symptoms and the type of discharge, which tends to be thick, white and yeasty-smelling.

Non-infective causes of abnormal vaginal discharge include a retained foreign body such as a tampon or condom, inflammation due to irritation or allergy (eg to soaps or lubricants), tumours of the vulva, vagina, cervix or endometrium, cervical erosion or polyps, and atrophic vaginitis, which can occur in post-menopausal women.

Back in the pharmacy, the woman tells you she has no symptoms other than the vaginal discharge, which she describes as more watery than usual and "smelling like old fish," particularly after sexual intercourse. You explain these are classic symptoms of BV, adding – when she asks in horror if she has an STI – that it is the most common cause of vaginal discharge in women of childbearing age and that the reason why it occurs is uncertain, but it is certainly not sexually transmitted and can occur in women who are not having sex.

Risk factors

Although BV isn't an STI, it is more common in women who are sexually active. It is also more common in those who have recently changed their sexual partner, black women, smokers and those who use an intrauterine device or system. Hormonal changes during the menstrual cycle and having unprotected sex also seem to increase the risk of developing BV, as do certain lifestyle factors such as using highly scented soaps or bath products, using vaginal deodorants or douches, and detergent residues on underwear.

Your patient says she recently started using a vaginal wash as she was worried that she might smell because she had more vaginal discharge than normal. On gentle questioning, you discover that this was around a month or so ago, and at the time the discharge wasn't smelly, just present in larger quantities than usual. You explain that increased discharge is entirely normal during pregnancy – particularly the second trimester – and add that vaginal deodorants and washes are not generally recommended (and certainly not during pregnancy).

Diagnosis

If there are no symptoms other than the characteristic fishy-smelling vaginal discharge, a diagnosis of BV is generally made, as long as the woman is considered at low risk of an STI (aged over 25 years and with no new sexual partners in the last 12 months), has not recently had a gynaecological procedure (including childbirth, miscarriage or termination), has not suffered BV recently or recurrently, and is not pregnant. If these criteria are not met, a speculum examination should be performed, and a vaginal swab taken for testing for infections and pH.

All pregnant women with suspected BV should undergo vaginal swabbing and pH testing to confirm the diagnosis before treatment is started.

The patient in front of you is five months pregnant, so you advise her to see her GP as soon as possible for testing. She says she will ask to be examined or referred when she sees the midwife the next day.

Management

Only women who have symptoms need to be treated, unless a pregnant woman is discovered to have BV during other tests (see Complications). Non-pregnant women who are asymptomatic but are diagnosed with BV (again, usually during other tests) should be allowed to opt for treatment if they wish.

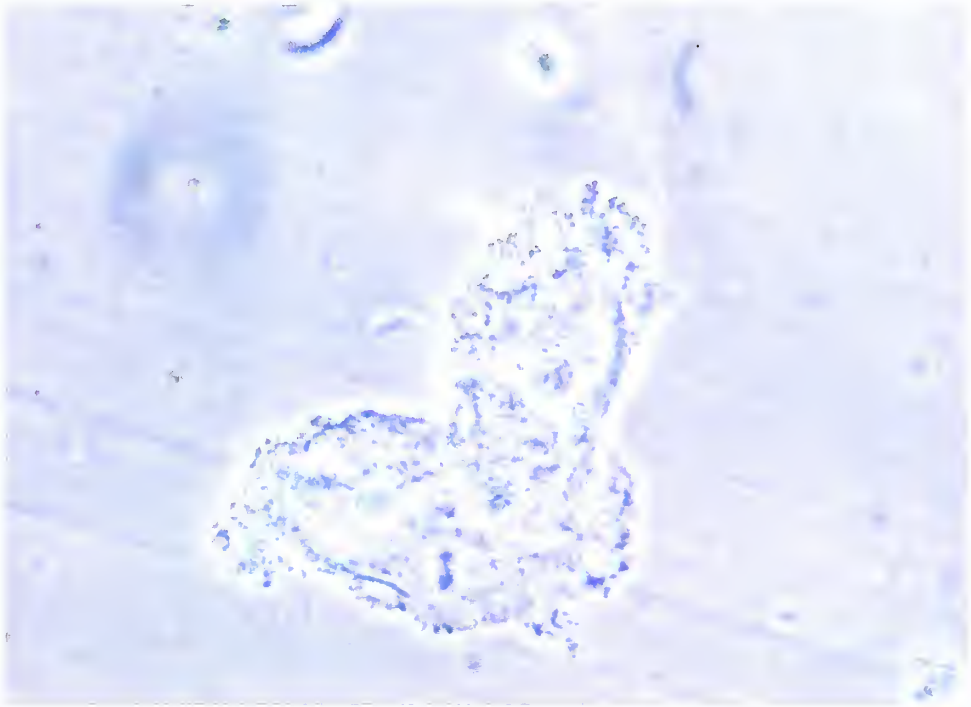
The recommended first-line treatment is metronidazole 400mg tablets, twice daily for seven days. The drug is around 80 per cent effective, well-tolerated and inexpensive. If treatment adherence is likely to be an issue, a single dose of metronidazole 2g may be used, though this is not thought to be as effective as the week's antibiotic course.

The main side effects are gastro-intestinal including nausea, vomiting, an unpleasant taste and furred tongue. Metronidazole enhances the effects of coumarin anticoagulants, fluorouracil, phenytoin and lithium. The main caution to patients is to avoid alcohol, which produces a disulfiram-like reaction.

For women who cannot tolerate oral metronidazole, intravaginal metronidazole gel (0.75 per cent, once daily for five days) or intravaginal clindamycin cream (2 per cent, once daily for seven days) may be used. Both are as effective as a weekly course of oral metronidazole but are considerably more expensive. Oral alternatives to metronidazole include clindamycin 300mg twice daily for seven days or tinidazole 2g as a single dose, though again neither is considered first-line because they are considerably more expensive than oral metronidazole, and there is less evidence supporting their use in BV.

The same treatments may be used in both pregnant and non-pregnant women, though topical clindamycin is considered safer during pregnancy than systemic, a metronidazole course is preferable to a single high dose, and tinidazole is not recommended during the first trimester.

Testing is not generally recommended to ensure treatment has worked – patient reporting of symptom resolution is considered sufficient. The only exception is pregnant women, who should be examined and tested one month after treatment to ensure the infection has cleared. Symptoms that do not resolve are usually due to poor treatment adherence or misdiagnosis.



Vaginal epithelial cells showing the 'stippled' appearance seen in bacterial vaginosis

You advise the woman that – if your diagnosis of BV is confirmed – she is likely to need a course of metronidazole. She says she has taken it in the past for a dental problem, but is worried it may harm her unborn baby.

Complications

BV is generally a straightforward condition – easy to diagnose and treat in symptomatic women, with low risk of complications or treatment failure. However, the exception is when BV occurs in pregnancy, when it is associated with late miscarriage, pre-term labour and birth, low birthweight and postpartum endometriosis. Similarly, BV has been found in some women who have had a miscarriage, gone into labour prematurely or had a low birthweight baby, though it is not known whether the infection was the cause of these events. For these reasons, women who have previously had a premature birth or recurrent miscarriages will usually be offered testing for BV (alongside other conditions, such as several STIs).

You reassure the patient that a course of metronidazole is considered safe for use in pregnancy and state that the benefits of treating the condition outweigh the risks of leaving it untreated (though you opt not to expand on the reasons why, deciding that this could cause her distress and is better dealt with by the midwife or GP once BV has been definitely diagnosed).

Recurrence

Although certain factors put women at a higher risk of BV, its onset and resolution can be spontaneous, hence the rationale for not treating asymptomatic sufferers. However, some women may suffer recurrent symptoms, and are considered to have recurrent BV if they suffer four times a year or more despite adhering to the recommended treatments as outlined above.

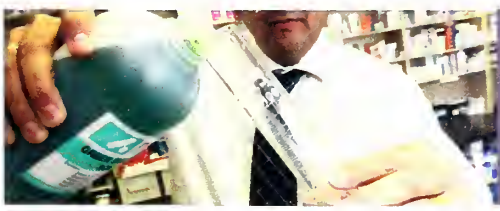
Such women should be referred to a gynaecologist or genito-urinary specialist, who may recommend using metronidazole 0.75 per cent gel twice weekly for four to six months (after initial treatment with oral metronidazole for 10 days) to suppress symptoms, or regular three-day courses of metronidazole 400mg tablets twice daily every menstrual cycle for a number of months. There is a lack of published evidence on treating women with recurrent BV.

Further information

- NHS Clinical Knowledge Summaries
www.cks.nhs.uk/bacterial_vaginosis/management
- British Association for Sexual Health and HIV
www.bashh.org/documents/62/62.pdf

Asha Fowells MRPharmS is a practising community pharmacist and a training development manager at C+D.

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.



NEXT WEEK
Addiction part 3: practical advice on implementing services to substance misusers

Bacterial vaginosis

Which bacteria are responsible for bacterial vaginosis? How do the symptoms of BV differ from those of thrush? Why should pregnant women with BV be treated even if they are asymptomatic?

This article describes the symptoms and treatment of bacterial vaginosis, with information about causes, risk factors, complications and the treatment of pregnant women.

Find out more about BV from the Patient UK website, including advice about preventing recurrence, at http://tinyurl.com/y9ppsjl.

More advice about BV can also be found at the Women's Health Concern website at http://tinyurl.com/ydqpyzc.

Read more about the treatment of BV in pregnancy at the NHS Clinical Knowledge Summaries website at http://tinyurl.com/ya4wy5b.

From the Patient UK website, revise your knowledge of other conditions that may cause a vaginal discharge at http://tinyurl.com/yce8ocp.

Are you now confident in your knowledge of the symptoms and treatment of bacterial vaginosis? Could you advise patients about this condition and how to prevent recurrence?

5 minute test
What have you learned?

Test yourself in three easy steps:

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Register for Update 2009 and receive a unique PIN number

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Access the 5 Minute Test questions on the C+D website at **www.chemistanddruggist.co.uk/mycpd**

Step 3

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Registering for Update 2009 costs £32.50 (inc VAT) and can be done easily at www.chemistanddruggist.co.uk/update or by calling 01732 377269. Signing up also ensures that C+D's weekly Update article is delivered directly to your inbox free every week with C+D's email newsletter.

Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online

Practical Approach

Identifying and treating female hirsutism

At the Update Pharmacy a young Asian woman has asked Kathy at the cosmetics counter for advice about removal of facial and body hair by laser or electrolysis. Kathy can see that the girl has quite thick, dark hair on her arms particularly, and refers her to Lydia Allen, the relief pharmacist, who is on duty today. In the consultation area, Lydia asks the girl how she can help.

"Well," she says, holding out her arms, "you can see the hair here. I've also got it on my thighs and on my face, although I keep that down by plucking. It's been getting gradually worse over the last couple of years and I want to get rid of it permanently. So I thought your assistant might be able to tell me about electrolysis or laser treatment, but she passed me on to you."

"That's because there might be some medical cause," Lydia replies, "and Kathy thought I'd be better qualified to find out. So could I ask you a few questions?"

The girl agrees, and Lydia first asks for her age, which is 20, and her height and weight from which Lydia calculates her BMI as 27. She then asks if the girl takes any medication, has ever had a problem with acne or has noticed her hair receding at the forehead. The answer to all of which is no.

Lydia then asks: "Are your periods regular?"

"Well, I don't have one every month," is the reply.

Questions

1. What is hirsutism, how common is it and what causes it?
2. Which drugs can cause hirsutism?
3. What was the point of Lydia's other questions?
4. What drug treatments are available for hirsutism?
5. What information could Lydia give about electrolysis and laser hair removal?

Answers

1. The presence of terminal hair (long, coarse, and pigmented) in women and girls, in a male androgen sensitive pattern. It affects 5 to 15 per cent of women of reproductive age. Androgens, principally testosterone (from the adrenal glands and ovaries), increase hair growth by converting fine, unpigmented vellus hair to terminal hair in androgen sensitive areas such as the face, chest and abdomen.

2. Some combined and progestogen-only oral contraceptives, anabolic steroids and sodium valproate.

3. Acne and/or a male balding pattern may indicate raised androgen levels, to which being overweight can contribute. Reduced or absent menstruation and hirsutism may indicate polycystic ovary syndrome (POS), which causes excessive androgen production.

4. Combined oral contraceptives containing the anti-androgens drospirenone (in Yasmin) or cyproterone (in Dianette); metformin for POS; eflornithine cream, a hair growth enzyme inhibitor.

5. Both processes remove hair for longer than cosmetic methods such as depilatory creams, but only small areas can be treated at a time (eg 25 to 100 hairs per 15 to 60 minute electrolysis session). Treatment is uncomfortable and even painful. Electrolysis should permanently eliminate hairs but there can be up to 25 per cent regrowth. Hair regrows, although less vigorously, after about six months following laser treatment. Both processes are expensive.

This article can help with these CPD competencies: **G1a, G1c, G1d, G2o, C1a.**
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ETHICAL DILEMMA

This series aims to help you make the right decisions when confronted by an ethical dilemma. In the last issue of every month we present a scenario likely to arise in a community pharmacy and ask a practising pharmacist and/or a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **ethics@cmpmedica.com**

Flu patient with wrong URN

The dilemma

Our pharmacy is an antiviral collection point nominated by the PCT. Mr X came in at 6.45pm with a URN (unique reference number) given by the Pandemic Flu Service for an antiviral. He presented his ID and said he was the patient. When keyed in the URN came up as 'not recognised'. We explained to the patient that the number was incorrect. I suggested he ring the Pandemic Flu service but they refused to give him another URN and advised him to contact his GP. From previous experience I knew the Flu Service would not be able to identify a patient from his name and address details. I phoned his surgery and found it was closed. The patient became irritable and expressed annoyance that I was unable to give him his antiviral.

Option 1

The Pandemic Flu Service has issued warnings about the fraudulent abuse of antivirals, which were being sold in markets or sent overseas. Consequently, the service was not issuing repeat URNs for multiple collections of antivirals. I was concerned that someone suffering from swine flu was fit enough to get to the pharmacy, which raised doubts about this being a genuine case. I had only one form of ID to go on, whereas a 'flu friend' would have given me another ID, reducing the chance of fraud. Giving him the antiviral would risk the patient misusing it.

Option 2

Mr X looked unwell and I was convinced he was suffering from flu as he purchased a thermometer, paracetamol and a hand scrub. There was no reluctance in my calling the Flu Line for confirmation of his URN and he was willing for me to ring the GP. I queried why he had visited the pharmacy and why a 'flu friend' could not have come. He convinced me that he was in the area for a consultancy contract and did not know anyone who could have come on his behalf. He said I could check his temperature.

The decision

Patient care was my prime concern, at the risk of patient fraud from the NHS. My assessment of Mr X was that he was unwell. I appreciated that he could have recorded an incorrect digit, something that could easily be done while making notes on the phone, particularly when someone is unwell. If I did not issue the antiviral, Mr X's health could have deteriorated and possible complications may have set in. His story that he was in the area for a consultancy contract was plausible. I issued the antiviral and told him I would contact his GP to advise him of the situation.

Lila Thakerar MRPharmS, pharmacist/owner of Shaftesbury Pharmacy, Harrow. Local press officer for National Pharmacy Association.

Where does the law stand?

Antivirals such as Tamiflu are prescription-only medicines. Section 58 of the Medicines Act 1968 prohibits the supply of a POM without a valid prescription from an appropriate practitioner.

However, the Prescription Only Medicine (Human Use) Order 1997 permits emergency supplies of a POM in certain circumstances if requested by a patient (Articles 8 (3) and 8 (4)). An emergency supply of up to 30 days can only be made at the request of the patient if: the pharmacist has interviewed the patient; there is an immediate need; the treatment has been prescribed on a previous occasion by an appropriate practitioner; the dose requested is appropriate.

These rules are relaxed somewhat during a pandemic (paragraph (12(F)), when a POM can be supplied where there is a government protocol in place and where certain information is recorded regarding the supply. The protocol authorises non-qualified practitioners, such as personnel working for the Flu Service, to supply antivirals.

However, if a supply is made outside the protocol, most of the rules on emergency supplies remain and the pharmacist will need to be satisfied that it meets the right criteria. Another option would be to refer the patient to an out-of-hours doctor.

Noel Wardle is a solicitor at Charles Russell LLP, specialists in pharmacy law.

This article can help in the following CPD competencies: **G1a, G1h, G1j, G1l, G3a, G7a, G7c, C1a. See http://tinyurl.com/68ox7b**

More dilemmas are online at www.chemistanddruggist.co.uk/ethicaldilemma

PLEA

PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement **www.wingfieldworks.co.uk/plea/index.html**

Next month's Ethical Dilemma
A pharmacy wrongly accused of credit card theft

From minor eye infections to acute bacterial conjunctivitis

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"By being proactive, pharmacies can engage customers further with this proven weight loss aid"
– Dr Terry Maguire, Fellow of the Royal Pharmaceutical Society of Northern Ireland

Pharmacy managers will strike their own balance between expanding services and business as usual. Are you satisfied enquiring into your customers' progress and giving tips on diet and exercise? Do you have the resources available to establish a full scale intervention with regular consultations and goal setting, weigh-ins and ongoing reviews?[3]

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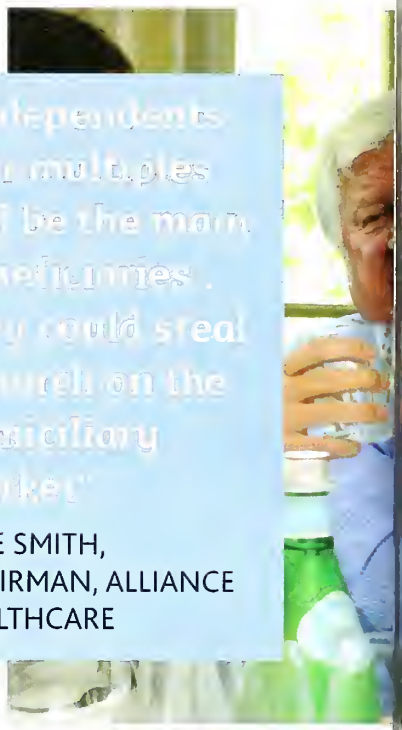


"Independents fear multiples will be the main beneficiaries . they could steal a march on the domiciliary market"

MIKE SMITH, CHAIRMAN, ALLIANCE HEALTHCARE

On the day the Responsible Pharmacist dawned, C+D convened an emergency meeting of our Senate to look at the practical issues facing grassroots pharmacists under the regs. Here's what they said

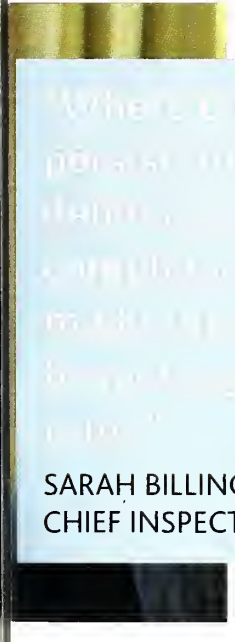
The Senators

Paul Bennett (PB)
Superintendent pharmacist, Boots
Sarah Billington (SB)
RPSGB chief inspector
Max Gosney (MG)
News editor, Chemist+Druggist
Mark Koziol (MK)
Chairman, PDA
Andrew McLean (AM)
UK marketing manager, Actavis
Nick Mortimer (NM)
Superintendent pharmacist, Lloydspharmacy
Gary Paragpuri (GP)
Editor, Chemist+Druggist
Amish Patel (AP)
Pharmacy manager, Hodgson Pharmacy, Dartford
Mike Smith (MS)
Chairman, Alliance Healthcare
Elaine Stevenson (ES)
Pharmacy manager, Manor Pharmacy, Wallington, Surrey
John Turk (JT)
Chief executive, NPA

MG: After much ado the RP regs have finally gone live today so what does the Senate think – is this a moment of liberation for the profession or a dangerous departure from the norm?
PB: I don't think it's either an opportunity or a threat. The world hasn't stopped spinning on the first of October. I think it is a regulatory burden that has been introduced without any enablement that was originally envisaged and until we get into a debate about supervision at the same time, I think it's a bit of a non-event.
NM: I think it's a missed opportunity. I think dealing with the RP in isolation without supervision was a flawed decision originally. My view is that one without the other is not helpful and it becomes a regulatory burden that we all have to comply with without the enabling bits-and-pieces which supervision may or may not deliver.
JT: The responsible pharmacist [without supervision] is like the strawberries without the cream, they need to go together. I think there is, certainly amongst our members, a degree of anxiety in terms of actually understanding what it means and some of the implications.
MS: I'm going to be a bit of a devil's advocate. I spend a lot of time speaking to independent pharmacists, and there is real concern that this will be an additional burden in the operation of their businesses. They fear that the main beneficiaries of RP will be the multiples and the supermarkets. The act will free up their pharmacists for two hours a day and they could steal a march on moving into the domiciliary market, which frankly is where pharmacy has to be in the future.
PB: I don't see it in that context. My perception of this is that we would share the same regulatory burden as our independent colleagues and don't see anything which advantages multiples in any way differently to our independent colleagues.

GP: Nick, do you share Paul's view?
NM: Very much so. The two-hour absence period to me is a red herring. Because if the pharmacist signs off for a temporary absence for a period of time within his two-hour allowed time, that pharmacy, effectively, cannot really function, it cannot work if that pharmacist has gone off for a meeting or lunch or whatever it may be. And that destroys our business model because the pharmacy cannot sell P-meds, it cannot dispense prescriptions or serve the public, which is what we're there to do. With respect to Mike, I can perhaps understand the angst of the independent, but from our perspective, as Lloydspharmacy, we certainly see it very much as business today as it was pretty much yesterday.
MK: Beyond the argument of whether anything changes for the pharmacist or not, there are huge consequences operationally. The pharmacist can't just leave and take a proper rest break and allow a

PAUL BENNETT, SUPERINTENDENT, BOOTS



SARAH BILLINGTON, CHIEF INSPECTOR, RPSGB

you remain signed in or whether you sign out as a temporary absence, I think is the nub of the problem. Previously a pharmacist, even when he was in personal control, would take a break and whether or not it was custom and practice, whether it was the law of the land, the pharmacy would continue to function.

My view is, going forward, that in a break situation, if a pharmacist remains on the premises I believe that that can carry on, as is. Now, I've read various pieces around this business of saying, does a break have to be an absolute break where you go into a state of zen. Or does it actually mean I just need 15 or 20 minutes away from the public, just to clear my mind. And as a company we're of the second school of thought on that.

That's how we intend to manage it.

PB: The thing that's missing for me is perhaps a clearer steer from our friends in Lambeth around regulation.

MG: Sarah, can you offer that guidance?

SB: We would regulate it as we've regulated before October 1, which is to engage and monitor compliance of legislation as we currently do. So we have several functions, one of which is to assist pharmacies and where we see non-compliance, as we do now, we assist and direct pharmacists on how they may comply.

If non-compliance is persistent we would go back and try again but eventually at the point where there is persistent non-compliance or deliberate non-compliance we might take a more formal regulatory route.

GP: How do you feel that failure to sign out of the RP register is a criminal offence?

NM: It does on the surface seem draconian. As a superintendent of a major multiple I am on occasion asked to identify who was working in a pharmacy on a given date, for any number of reasons. That's been one of the biggest challenges of my job.

Now I do welcome the need to sign in and out. We have devised an electronic version of the register to allow our pharmacists to do that. And it will give me the confidence that I can make those identifications if needs must.

I think taking the point of, is it draconian, doctors don't do this, other healthcare professionals don't have to indulge in the same activity, I think you can regard that as a little unfair.

GP: Is it a bit draconian that if you forget to sign off you can't then speak to whoever is RP after you the following morning, explain the situation, and ask them to make an entry on your behalf?

SB: We all, inadvertently, do things that we didn't intend to do. But I would say the regulator would look at what pragmatic solution you found

lot of things to go on in the pharmacy because they are now covered in statute. You have to have a responsible pharmacist signed on to allow that pharmacy to operate normally.

People are very worried and concerned because this is a very big change to them. Nobody wants to go to work not knowing exactly what the arrangements are. And the more they find out what the arrangements are, the more they realise that they are unworkable and it's like being in a Houdini trick without the ability to get out of it.

GP: What are your plans around rest breaks and what difference does RP make to your plans?

NM: I don't think RP has changed the way we will deal with rest breaks. I mean rest breaks are a fact of life. We expect our staff to take them, we expected our staff to take them prior to RP and we expect them to take them post-RP. We expect them to act as a professional to work out the time that the break is most appropriate.

Now the issue that Mark has highlighted about the carrying on of the responsibility of whether

NICK MORTIMER, SUPERINTENDENT, LLOYDSPHARMACY

for that. For example, they could look to show they've collected the right material and tried with the best of intentions to meet the requirements.

GP: So, from today when the inspectors go out?

SB: They will say – yes, that's a good idea. Just make a record of it and as long as the superintendent is happy, shame that someone forgot, but that's life.

NM: I think there's a difference between one-off forgetting and systematic disregard for the register.

SB: Absolutely.

ES: I think there's got to be a common sense approach. If I forgot to sign out, I would email my superintendent and make written records of why it had happened, how it had occurred, apologise and say I will endeavour not to do that again. And I would assume if one of your colleagues came in to inspect me they would see that was reasonable.

AP: Do you not find that an additional burden now? On top of everything else we have to do there's another folder that we have to keep in our pharmacy for five years, worrying about making sure that we do sign out. If we don't sign out making sure we follow the correct procedure to overcome the problem that we haven't signed out. It's just additional work which is unnecessary.

MG: Are you both RPs, from today?

ES: Indeed.

MG: And what have you done to prepare for that?

AP: I've made sure my SOPs are in place, I've got my folder with about a year's worth of record sheets in it for now. And I've put my sign up. So, as such it's no different to going into work yesterday. Other than that there are the few issues of accepting deliveries. My dispenser is usually in the pharmacy by 8am and accepts deliveries. But if there are CDs in that delivery now, he's going to have to send that delivery back. It's going to be a backward chain. Our wholesaler driver loves the fact that he's in early because he gets to finish his deliveries on time and get to all the other stores.

GP: Maybe it's worth picking up on how the roles have changed, if they have changed, between the superintendent pharmacist and the RP.

PB: A superintendent has always been accountable for establishing a clinical governance framework and he usually does that and discharges that responsibility through the creation of a suite of standard operating procedures, policies and procedures of operations for the business. That does not change under the introduction of the responsible pharmacist rules.

What the RP, as we know, is required to do is to establish and maintain those standard operating procedures, as they relate to the local practice in the pharmacy in which they are an RP. There has always been and will continue to be a professional accountability for the individual practitioner in the store. So I see it not as a conflict. I see it as a partnership in patient care.

GP: So what sorts of level of support will RPs get from superintendents?

NM: Well, it's very much a two-way street, Gary. I think we have to work with our pharmacists; as Paul says, it's not a conflict, it has to be a partnership to work together. It is around helping with professional issues.

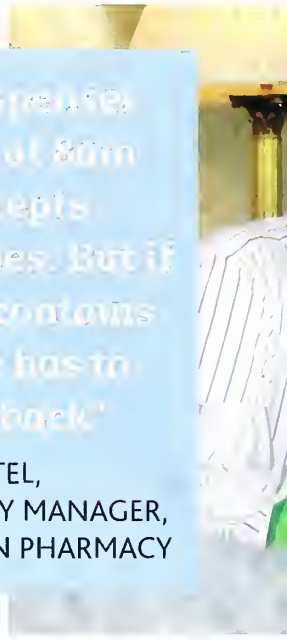
We've got two types of variants, potentially in SOPs. There's a temporary amend which is driven by circumstances, on a given day. And there's a more permanent amend, if the nature of the business necessitates it. And I'll be honest that as a company we have a number of pharmacies that run to specifically tailor-made SOPs.

So we do not have one size fits all. We fully accept, and we've built into our systems, that there will be occasions where a pharmacist arrives and the dispenser doesn't because they're off sick and there will need to be some arrangements with the local field manager to obtain a replacement: temporary cover staff who will be transferred to the branch.

ES: There is also an element of real benefit in this. For the first time, I'm not frightened to say, it's made me look at some of my own procedures, it's enabled me to make a better service for patients. There are some frightening elements, but it's also put me in a better position to go to my superintendent and say, OK I understand the commercial benefit, but hold on,

"My dispenser arrives at 8am and accepts deliveries. But if it now contains CDs, he has to send it back"

AMIS PATEL, PHARMACY MANAGER, HODGSON PHARMACY



can we not do it this way because that would make my business run more safely and effectively for, ultimately, my patients and my community.

MK: There has always been a partnership between the superintendent and the pharmacist in personal control, but it's been a different relationship to the one that existed before today. If we use an analogy, before it was much more a master/servant relationship, today it's more like a marriage.

My concern is it's the responsible pharmacist that is held statutorily responsible for establishing SOPs. We've curiously got ourselves into a situation where those who are generating the standards, the superintendents, will not, according to these new regulations, be held statutorily responsible for those standards because it will be the guys on the receiving end, the RPs, who are in the pharmacy.

GP: Can I ask, is it a good or a bad thing that the RP has greater power than before?

MK: It's a very good thing. Our argument is about the way it has been done. There has been nowhere near sufficient preparation. When you introduce the big bang approach, which is what we've effectively had today, what you end up with is a whole stack of problems at the kick off.

And I heard what was said earlier about common sense will prevail. I sat in a room with Elizabeth Lee where common sense should have prevailed. It did not.

That's why it is too important to just sweep some of these issues under the carpet. Oh, it'll all be OK because we all live in the valleys of Switzerland and pick daisies in the afternoon, because life isn't like that. We now need to try to find solutions.

For example, one practical problem that we haven't yet talked about is that the pharmacist has to be able to digest the SOP effectively before signing on. I've already seen some head office memos saying sign on as soon as you arrive, you can have a look at the SOPs later. I think the solution needs to be that the profession needs to develop a very simple top-line, no more than one and a half pages, universal SOP.

So, we can come up with an industry-acceptable, top-line, headline SOP that pharmacists and locums in particular can carry

"It [pods] ... enabled me to make a better service for patient..."

ELAINE STEVENSON, PHARMACY MANAGER, MANOR PHARMACY

MARK KOZIOL, CHAIRMAN, PDA

with them and even memorise like the 10 commandments.

NM: It's a very interesting point. It depends I think on what you believe an SOP is, or what it's designed to be. We have worked very hard to cut back our SOPs and pared them down to the bare minimum for this year for RP. They run to 198 pages to cover the various aspects that are covered in the legislation. And we worked hard to reduce that. And I would welcome if we could do it. I do have some scepticism around how practical [this is], whether a page and a half is too optimistic, whether it becomes a bigger document. I don't know.

The way we've tried to tackle it is that we have taken our locum database and sent copies of our SOPs in advance to people we know who work for us regularly.

It still leaves me with what I call the emergency situation of the manager's gone sick this morning, phoned his area manager, he's phoned the locum agency and said "we need someone today at 9am". And that may be someone who's never set foot in a Lloydspharmacy before and I fully appreciate that. And that could potentially be an issue and I think that's maybe something we could explore further, if we could look at that type of scenario.

What I would want to do is work with the regular locums that I have because I fully accept Mark's point that locums are a fact of life going forward; they are not going to become extinct. We need to engage with them as a company.

PB: I see the benefit of a single approach, that's what we've done internally. Whether you can take that out across 12,000 pharmacies is another matter entirely because while they're not specific about what product goes on what shelf, they are absolutely integral to the way we work our stores.

So I'd like to explore the idea further that Mark proposes and wouldn't push that away. But there are some very obvious natural challenges involved in that but that doesn't mean we shouldn't look at it.

GP: What advice is the Society giving to pharmacists about checking the SOP on arrival?

SB: Well, we would have said that before today they had to be able to assure themselves that they could secure the safe running of that pharmacy and if it's completely unfamiliar to them they must go through some process of familiarising themselves with how that pharmacy runs. And I would say it's a matter of professional judgement whether you felt you had to read them all or not.

MK: Another possible solution is being able to sign in or out of the register electronically. Why not sign on at 8am before you've arrived at the pharmacy? If you are the regular manager and you have made contact with the pharmacy to check all is well, it would be entirely appropriate to do that if it's your regular pharmacy and you're confident that the SOPs can secure the safe and effective running of the pharmacy.

GP: Is this something the NPA would lobby for?

JP: I suppose the answer is, yes, if we needed to. But I think it would be a bit bizarre given the sums of money we're spending on EPS that if we are moving prescriptions around electronically that at the same time we couldn't record whether we're there or not, electronically.

PB: I think the acid test of all this to me is – so what difference has RP made to our patients? And at this moment I see very little difference. With a full and thorough debate about supervision, hopefully there will be significant benefit to our patients.

I guess the one big lesson I hope we can learn from events up to October 1 with RP is that if we've got particular issues that we all passionately believe in, we should take time to talk to each other about them, flush them out earlier on so we don't end up on the eve of implementation with new issues to deal with. Because that doesn't help our practitioners at the coalface.

The Senate ruling

- Opinion is divided over what impact RP will have – could supervision bring greater clarity?
- RP shouldn't deny pharmacists rest breaks – staff should be taking time out when appropriate
- One-off offenders should not be penalised for forgetting to sign the register. Criminal sanctions must only be used against serial offenders
- RPs must work as a team with superintendents to make sure pharmacies are safe and offer the best service to patients
- Industry to investigate the possibility of a universal SOP. This would ensure pharmacists have some familiarity with working practices before signing on at a new pharmacy
- RPs must be allowed to sign the register electronically to give greater flexibility to pharmacists
- The industry must sit down and discuss major professional issues like RP much earlier. Some of the problems we face are a result of sweeping things under the carpet. We must stand together to tackle what comes next

Senate extra: what happens after RP? How will supervision changes impact on pharmacies? Read the Senate's view

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My pharmacy life

Beta Buying Group head Shafique Govani describes joining community pharmacy from the finance sector

The fascinating thing about community pharmacy is that there are so many perspectives. Before I joined the industry, I would've thought it was not that dynamic, but then I saw that many changes were taking place and there were many dimensions that I had to consider.

I studied in Sweden where I was born. I did international business and marketing in Gothenburg, then moved to London and got a job in market research and analysis at HSBC. After a sabbatical working for a charitable organisation for a year, I was going back to the bank when I met up with a member of Beta Buying Group – that's when I decided to join pharmacy.

I was persuaded by the culture of the group. It was a dynamic team where your voice counts, your input is valued and you're given responsibility to drive projects forward. Coming into pharmacy was difficult, of course, because my background before that was entirely in the financial industry. So it took a bit of time to understand the culture of the pharmacy world: the way people operate, the nature of the business.

But once I got to know the way pharmacists think then it was business as usual because, at the end of the day, when you talk about marketing and communications and management it comes down to the same principles whichever industry you work in.

I took charge of the Beta Buying Group five years ago and my job is to liaise with members and suppliers, source new members, get new deals and promote our services. We have a team in place that is the brains behind the buying group – a think-tank, if you like – which has pharmacists on board. Their job is to identify the issues that we need to tackle and then it comes down to me and the team to manage and market it. I enjoy the opportunity to communicate to people and that my marketing background brings something different to the group.

Shafique Govani: "Constant new challenges keep you driven"

Top of my 'to do' list at the moment is trying to communicate to members what PNAs [pharmaceutical needs assessments] are all about. We want to highlight to them what impact it will have on them and their pharmacy operations, and the need to pay attention to the changes that are taking place at quite a rapid pace.

The nature of the buying group is also changing, so we have to ensure that we move with the times. The industry is not what it was five years ago; we need to be looking proactively all the time, making sure we understand the needs and the changes that are taking place, and that we address them appropriately.

We are a non profit making buying group so any income kickback that we get is distributed 50 per cent back to the membership and 50 per cent into charitable causes. We invest in humanitarian projects, education projects and medical projects, both in the UK as well as in third world countries – projects such as building water wells, arranging food programmes or, in the UK, for example, we sponsored a golf tournament where all the funds raised went to cancer research.

I am proud that we have been able to grow so quickly in such a short time and engage in so many charitable projects as a result of driving the Beta Buying Group forward.

In my spare time, my number one priority is trying to spend as much time as possible with my family. And I'm very keen on sports, so I play football on Saturday mornings at 8am, and volleyball. I'm also a teacher at the community Sunday school, where I was principal for three years until last year.

Community pharmacy is so dynamic. There are constantly new challenges and that keeps you driven all the time. And the charitable projects that we are investing in is a driving factor as well. The more financial value that's brought to the Beta Buying Group, the more we can invest in charity.

When you come into the office in the morning you know that the more effort that you put into this buying group, the more value you can generate for people who are not as fortunate as you are. That's the ultimate driving factor for me. I wish we could do more, but that's another driving factor in itself.

Career tip of the week

"When supplying constructive criticism you must not blame the person. The purpose of explaining a person's failings to them is to help them address the problems caused by those failings. If you blame them for their failings they are very unlikely to listen to any constructive criticism. Make sure you do not fall into the trap of creating a blame culture in your team."

From Brilliant manager, by Nic Peeling

www.chemistanddruggist.co.uk/books-for-pharmacists

Career ladder

... at Avicenna

Buying group Avicenna has named accountant Matthew Thomas as financial controller. In the newly-created role, Mr Thomas will be responsible for improving measurement of Avicenna's performance, as well as working with the board on the group's growth programme.

... at the NPA

BT Health director of communications Nicola Rossi is set to join the NPA, also as director of communications. From December, Ms Rossi will be responsible for strengthening the NPA's voice in policy making. She has spent over 20 years in communications at BT.

... at Procter & Gamble

Procter & Gamble has expanded its PharmacyCare team, which works with pharmacies to re-merchandise and increase retail sales. Joanna Dee (pictured) has been promoted to commercial manager for consumer healthcare and pharmacy, and is now also responsible for managing P&G healthcare brands Vicks, Clearblue and Pepto-bismol. Adam Bishop joins as pharmacy channel team leader after six years at P&G and will be responsible for the commercial side of the PharmacyCare Programme.

... at Phoenix

Wholesaler Phoenix has made two appointments to its business development team. Matthew Jones is business development manager after 14 years in the Phoenix Group, most recently as retail NHS buyer, and will be responsible for developing manufacturer relationships. Adrian Davies has been appointed as partner contracts analyst after 10 years in finance roles. The expansion reflects "more and more manufacturers" selecting Phoenix as a distribution partner, said UK group business development manager Nick Cartwright.

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*Linda Jones Associates Industry Survey 2009

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

A delicate situation...

Things got a little serious here for a moment this week when I was approached by a young girl who needed help. She had missed two periods and when a pregnancy test came up positive she came in for advice about what she could do next.

She had been to see her GP, who had given her the impression he could do nothing unless she spoke to her parents. She didn't want to do that because she was afraid her whole world could fall apart.

To some extent I felt out of my depth. I was certainly out of my comfort zone, but as she had reached out to me I had to do something.

Suddenly my whole day became engulfed by this issue. My immediate concern was for her welfare, particularly her emotional wellbeing – she was obviously worried and looked like she needed a cuddle from her mum. She was so frightened that she wouldn't even give me her name.

Typically, there was nobody around to get advice from, as the whole Safeguarding team for Dorset was stuck in a training session!

Eventually I got somebody on the phone, and was able to talk the scenario through and come up with an action plan. Fortunately I was able to guide her to an appropriate source of care.

A job well done, but some definite lessons learnt for next time.

> "I WAS CERTAINLY OUT OF MY COMFORT ZONE, BUT AS SHE HAD REACHED OUT TO ME I HAD TO DO SOMETHING"

Raiders of the lost archives

C+D 1859-2009
Celebrating 150 years in pharmacy

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C+D came down hard against smoking back in September 1860, when it revealed smoking cigarettes makes you stupid.

In a study reported by C+D, the Polytechnic School in Paris split the school into smokers and non-smokers, and had a look at their exam scores.

"Smokers have proved themselves in the various competitive examinations far inferior to others," said C+D.

"Not only in the examinations on entering the school are smokers in a lower rank, but in the various ordeals they have to pass through in a year, the average rank of smokers has constantly fallen... while the men who did not smoke enjoyed a cerebral atmosphere of the clearest kind."

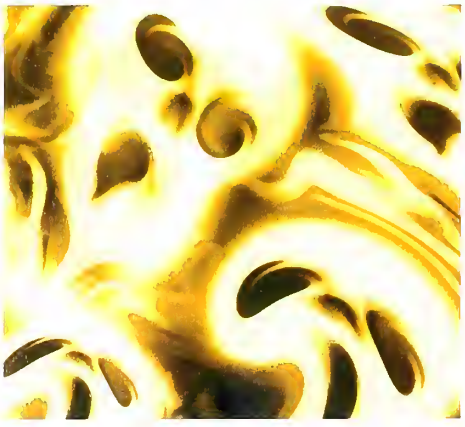
The study came at the same time as a letter to The Times from Sir B. Brodie, which concluded "smoking was injurious" and should be stopped.

Raiders of the Lost Archives likes to think that C+D's editor nodded sagely at these results, before lighting his cigar and puffing away contentedly.

On the trail of pharmacy's most haunted

Don your bedsheets, practise your 'boo' noises and prepare to scare kids eager to nick your sweets: it's time for Postscript's Halloween spooktacular.

Postscript tried to find a haunted pharmacy in the UK, without much success. The best we could come up with was an account from Burton on Trent, where a woman visiting her local pharmacy fell into screaming hysterics. When she came round, she told the pharmacist she'd seen a filthy tramp "holding his hands out to me and pleading in a horrible guttural sound". According to website burtonghostandhistorywalk.co.uk, other people have also seen tramps in Burton on Trent. Scary.



However, we came across a more goosebumps-guaranteed experience for those willing to travel to Houston, Texas, where the city's Spaghetti Warehouse restaurant has been named the United States' sixth most-haunted spot.

The story goes that the restaurant used to be a pharmacy warehouse, and one day the pharmacist accidentally fell down an elevator shaft. His missus, who died a year later (predictably, "of a broken heart"), now lurks about the place turning the lights off and on. Obviously, it's a case for Ghostbusters rather than an electrician.

For those who prefer to stay at home and watch telly rather than seeking things that go bump in the night, Postscript's managed to track down a few TV treats to enjoy. We've already mentioned zombie horror movie 28 Days Later's ragtag survivors include a pharmacist, but for something a little more down to earth, try US crime drama Criminal Minds. In the latest series currently airing in the US, episode 'Haunted' sees the FBI profilers hunting down someone who popped into his local pharmacy for a killing spree.

And if you get your frights from the supernatural, turn to Channel 4 and watch the ghoulishly clever drama True Blood, where vampires are living among the citizens of a sleepy Louisiana town thanks to newly-developed synthetic blood. Ah, the wonders of modern medicine.

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Presentation: Lyrica is supplied in hard capsules containing 25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg (for Generalised Anxiety Disorder only) or 300mg of pregabalin. **Indications:** Treatment of peripheral and central neuropathic pain in adults. Treatment of epilepsy, as adjunctive therapy in adults with partial seizures with or without secondary generalisation. Treatment of Generalised Anxiety Disorder (GAD) in adults. **Dosage:** *Adults* 150 to 600mg per day, given in either two or three divided doses taken orally. Treatment may be initiated at a dose of 150mg per day and, based on individual patient response and tolerability, may be increased to 300mg per day after an interval of 3-7 days (for neuropathic pain) or 7 days (for epilepsy or GAD), the dose may be increased to 450mg per day after an additional 7 day interval (for GAD), and to a maximum dose of 600mg per day after a further 7 day interval. Treatment should be discontinued gradually over a minimum of one week. *Renal impairment/ Haemodialysis* dosage adjustment necessary, see SmPC. *Hepatic impairment* No dosage adjustment required. *Elderly* Dosage adjustment required if impaired renal function. *Children and adolescents* Not recommended. **Contra-indications:** Hypersensitivity to active substance or excipients. **Warnings and precautions:** There have been reports of hypersensitivity reactions, including cases of angioedema. Pregabalin should be discontinued immediately if symptoms of angioedema, such as facial, perioral, or upper airway swelling occur. Patients with galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take Lyrica. Some diabetic patients who gain weight may require adjustment to hypoglycaemic medication. Occurrence of dizziness and somnolence could increase accidental injury (fall) in elderly patients. There have also been post marketing reports of loss of consciousness, confusion and mental impairment. Cases of renal failure have been reported and discontinuation of pregabalin did show reversibility of this adverse effect. In controlled studies, a higher proportion of patients treated with pregabalin reported blurred vision than did patients treated with placebo which resolved in a majority of cases with continued dosing. In the clinical studies where ophthalmologic testing was conducted, the incidence of visual acuity reduction and visual field changes was greater in pregabalin-treated patients than in placebo-treated patients; the incidence of fundoscopic changes was greater in placebo-treated patients. In the postmarketing experience, visual adverse reactions have also been reported, most of which refer to transient vision loss, visual blurring or other changes of visual acuity. Discontinuation of pregabalin may result in resolution or improvement of these visual symptoms. Suicidal ideation and behaviour have been reported in patients treated with anti-epileptic agents. A meta-analysis of randomised placebo controlled trials of anti-epileptic drugs has also shown a small increased risk of suicidal ideation and behaviour. The data does not exclude the possibility of an increased risk for pregabalin. Patients should be monitored for signs of suicidal ideation and behaviours and appropriate treatment should be considered. Patients (and caregivers of patients) should be advised to seek medical advice should signs of suicidal ideation or behaviour emerge. Insufficient data for withdrawal of concomitant antiepileptic medication, once seizure control with adjunctive Lyrica has been reached, in order to reach monotherapy with Lyrica. After discontinuation of short and long-term treatment withdrawal symptoms have been observed in some patients; insomnia, headache, nausea, diarrhoea, flu syndrome, nervousness, depression, pain, sweating and dizziness. The patient should be informed about this at the start of the treatment. Concerning discontinuation of long-term treatment there are no data of the incidence and severity of withdrawal symptoms in relation to duration of use and dosage of pregabalin (see side effects). There have been post-marketing reports of congestive heart failure in some patients receiving pregabalin. These were mostly elderly, cardiovascular compromised patients who received treatment for a neuropathic indication. Pregabalin should be used with caution in these patients. Discontinuation of pregabalin may resolve the reaction. **Ability to drive and use machines:** May affect ability to drive or operate machinery. **Interactions:** Pregabalin appears to be additive in the impairment of cognitive and gross motor function caused by oxycodone and may potentiate the effects of ethanol and lorazepam. In the postmarketing experience, there are reports of respiratory failure and coma in patients taking pregabalin and other CNS depressant medications. **Pregnancy and lactation:** Lyrica should not be used during pregnancy unless benefit outweighs risk. Effective contraception must be used in women of childbearing potential. Breast-feeding is not recommended during treatment with Lyrica. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly (≥ 1/10) reported side effects in placebo-controlled, double-blind studies were somnolence and dizziness. Commonly (>1/100, <1/10) reported side effects were appetite increased, euphoric mood, confusion, libido decreased, irritability, ataxia, disturbance in attention, coordination abnormal, memory impairment, tremor, dysarthria, paraesthesia, vision blurred, diplopia, vertigo, dry mouth, constipation, vomiting, flatulence, erectile dysfunction, fatigue, oedema peripheral, feeling drunk, oedema, gait abnormal and weight increased. See SmPC for less commonly reported side effects. After discontinuation of short and long-term treatment withdrawal symptoms have been observed in some patients; insomnia, headache, nausea, diarrhoea, flu syndrome, nervousness, depression, pain, sweating and dizziness. Concerning discontinuation of long-term treatment there are no data of the incidence and severity of withdrawal symptoms in relation to duration of use and dosage of pregabalin (see warnings and precautions). In the post-marketing experience, the most commonly reported adverse events observed when pregabalin was taken in overdose included somnolence, confusional state, agitation, and restlessness. **Legal category:** POM. **Date of revision:** December 2008. **Package quantities, marketing authorisation numbers and basic NHS price:** Lyrica 25mg, EU/1/04/279/003, 56 caps: £64.40; EU/1/04/279/004, 84 caps: £96.60. Lyrica 50mg, EU/1/04/279/009, 84 caps: £96.60; Lyrica 75mg, EU/1/04/279/012, 56 caps: £64.40, Lyrica 100mg, EU/1/04/279/015, 84 caps: £96.60, Lyrica 150mg, EU/1/04/279/018, 56 caps: £64.40; Lyrica 200mg, EU/1/04/279/021, 84 caps: £96.60, Lyrica 300mg, EU/1/04/279/024, 56 caps: £64.40; Lyrica 225mg, EU/1/04/279/034, 56 caps: £64.40. **Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich, Kent, CT13 9NJ, UK. Lyrica is a registered trade mark. **Further information is available on request from:** Medical Information Department, Pfizer Limited, Walton Oaks, Dorking Road, Walton-on-the-Hill, Surrey KT20 7NS.

REFERENCES: 1. van Seventer R *et al. Curr Med Res Opin.* 2006;22:375–384. **2.** Siddall PJ *et al. Neurology* 2006;67:1792–1800. **3.** Portenoy R *et al.* Pregabalin for painful diabetic peripheral neuropathy and postherpetic neuralgia: onset and duration of analgesia in combined analyses of clinical studies. Poster presented at the 25th Annual Scientific meeting of the American Pain Society, San Antonio, Texas, 3–6 May 2006. **4.** Freynhagen R *et al. Pain* 2005;115:254–263.

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